Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0241	A. BUILDING: _____ B. WING _____	R 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART HOMES AT PINEY ORCHARD	8735 PINEY ORCHARD PARKWAY ODENTON, MD 21113

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E 000	Initial Comments The following deficiencies are the result of an unannounced monitoring survey conducted on 01/30/14 at Heart Homes at Piney Orchard, for determining the facility ' s compliance with COMAR 10.17.14, Assisted Living Program Regulations. Survey activities included an environmental tour, interview with staff, review of six (6) resident records and five (5) staff records. The facility ' s census at the time of survey was thirteen (13) residents.	E 000		
E2000	.13 A .13 Administration .13 Administration. A. Quality Assurance. (1) The assisted living program shall develop and implement a quality assurance plan. (2) Quality Assurance Plan. (a) The assisted living manager and the delegating nurse shall meet at least every 6 months to review the: (i) Change in status of the program's residents; (ii) Outcomes of pharmacy reviews; (iii) Service plan requirements; and (iv) Written recommendations or findings of the consultant pharmacist, as required by Regulation .29I of this chapter. (b) The assisted living manager shall document the proceedings of the meeting referred to in §A(2)(a) of this regulation. This REQUIREMENT is not met as evidenced by: 10.07.14.13. A (2) Based on administrative record review, the assisted living manager (ALM) and the delegating nurse failed to meet at least every six months to review the change in status of the program ' s	E2000		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E2000	Continued From page 1 residents, outcomes of pharmacy reviews, service plan requirements and written recommendations or findings of the consultant pharmacist. Findings include: Review of administrative records failed to reveal documentation the ALM and the delegating nurse met at least every six months to review the change in status of the program ' s residents, outcomes of pharmacy reviews, service plan requirements and written recommendations or findings of the consultant pharmacist. Interview with the ALM revealed the last quality assurance review was conducted on 6/1/13.	E2000		
E2560	.19 B3 .19 Other Staff--Qualifications (3) Have no criminal convictions or criminal history that indicates behavior that is potentially harmful to residents, as evidenced through a criminal background check completed within 30 days before employment; This REQUIREMENT is not met as evidenced by: 10.07.14.19. B (3) Based on staff record review, the facility failed to provide documentation that staff had no criminal convictions or criminal history that indicates behavior that is potentially harmful to residents, as evidenced through a criminal background check completed within 30 days before employment. Findings include: Review of Staff member # 2 ' s record failed to reveal documentation that Staff member # 2 had no criminal convictions or criminal history that	E2560		

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E2560	Continued From page 2 indicates behavior that is potentially harmful to residents, as evidenced through a criminal background check completed within 30 days before employment.	E2560		
E2630	.19 C .19 Other Staff--Qualifications C. With the exception of certified nursing assistants (CNAs) and geriatric nursing assistants (GNAs), if job duties involve the provision of personal care services as described in Regulation .28D of this chapter, an employee: (1) Shall demonstrate competence to the delegating nurse before performing these services; and (2) May work for 7 days before demonstrating to the delegating nurse that they have the competency to provide these services, if the employee is performing tasks accompanied by: (a) A certified nursing assistant; (b) A geriatric nursing assistant; or (c) An individual who has been approved by the delegating nurse. This REQUIREMENT is not met as evidenced by: 10.07.14.19. C (1) Based on staff record review, staff failed to demonstrate competence in performing personal care services to the delegating nurse. Findings include: Staff members #3 and #4 provide personal care services to residents. Staff member # 3 was hired on 7/9/13. Staff member #4 was hired on 10/18/13. Review of Staff members # 3 and #4 ' s records failed to provide documentation that staff members #3 and #4 demonstrated competence in performing personal care services to the	E2630		

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E2630	Continued From page 3 delegating nurse within the first seven days of hire.	E2630		
E2670	.19 G1,2 .19 Other Staff--Qualifications G. Training in Cognitive Impairment and Mental Illness. (1) When job duties involve the provision of personal care services as described in Regulation .28D of this chapter, employees shall receive a minimum of 5 hours of training on cognitive impairment and mental illness within the first 90 days of employment. (2) The training shall be designed to meet the specific needs of the program's population as determined by the assisted living manager including the following as appropriate: (a) An overview of the following: (i) A description of normal aging and conditions causing cognitive impairment; (ii) A description of normal aging and conditions causing mental illness; (iii) Risk factors for cognitive impairment; (iv) Risk factors for mental illness; (v) Health conditions that affect cognitive impairment; (vi) Health conditions that affect mental illness; (vii) Early identification of and intervention for cognitive impairment; (viii) Early identification of and intervention for mental illness; and (ix) Procedures for reporting cognitive, behavioral, and mood changes; (b) Effective communication including: (i) The effect of cognitive impairment on expressive and receptive communication; (ii) The effect of mental illness on expressive and	E2670		

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E2670	Continued From page 4 receptive communication; (iii) Effective verbal, nonverbal, tone and volume of voice, and word choice techniques; and (iv) Environmental stimuli and influences on communication; (c) Behavioral intervention including: (i) Identifying and interpreting behavioral symptoms; (ii) Problem solving for appropriate intervention; (iii) Risk factors and safety precautions to protect the individual and other residents; and (iv) De-escalation techniques; (d) Making activities meaningful including: (i) Understanding the therapeutic role of activities; (ii) Creating opportunities for productive, leisure, and self-care activities; and (iii) Structuring the day; (e) Staff and family interaction including: (i) Building a partnership for goal-directed care; (ii) Understanding families needs; and (iii) Effective communication between family and staff; (f) End of life care including: (i) Pain management; (ii) Providing comfort and dignity; and (iii) Supporting the family; and (g) Managing staff stress including: (i) Understanding the impact of stress on job performance, staff relations, and overall facility environment; (ii) Identification of stress triggers; (iii) Self-care skills; (iv) De-escalation techniques; and (v) Devising support systems and action plans.	E2670		

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E2670	Continued From page 5 This REQUIREMENT is not met as evidenced by: 10.07.14.19 G. (1) (2) Based on staff record review, documentation that all staff received five hours of cognitive impairment and mental illness within 90 days of hire was not available. Findings include: Staff member #4 was hired on 10/18/13. Review of Staff member # 4 ' s record revealed no documented evidence that Staff member #4 received the five hour training in cognitive impairment and mental illness within 90 days of hire.	E2670		
E2730	.19 G4 .19 Other Staff--Qualifications (4) Ongoing training in cognitive impairment and mental illness shall be provided annually consisting of, at a minimum: (a) 2 hours for employees whose job duties involve the provision of personal care services as described in Regulation .28D of this chapter; and (b) 1 hour for employees whose job duties do not involve the provision of personal care services as described in Regulation .28D of this chapter. This REQUIREMENT is not met as evidenced by: 10.07.14.19. G.4 (a) Based on staff record review, documentation that all staff who provides personal care to residents received two hours of cognitive impairment and mental illness training annually was unable to be found.	E2730		

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E2730	Continued From page 6 Findings include: Review of Staff member #1 ' s record failed to reveal documentation that Staff member #1 who provides personal care to residents received two hours of cognitive impairment and mental illness training annually.	E2730		
E2800	.21 A .21 Preadmission Requirements .21 Preadmission Requirements. A. Before Move In. (1) Before admission the assisted living manager or designee shall determine whether: (a) The resident may be admitted under the assisted living program's licensure category; and (b) The resident's needs can be met by the program. (2) Within 30 days before admission, the assisted living manager or designee shall determine admission eligibilities described in §A(1) of this regulation based on completion of a resident assessment using the Resident Assessment Tool as described in §B of this regulation. The Department may modify the level of care determination made by the assisted living program at any time. The Resident Assessment Tool: (a) Determines the resident's required level of care; (b) Forms the basis for development of the resident's service plan; and (c) Determines whether the resident needs awake overnight monitoring. This REQUIREMENT is not met as evidenced by: 10.07.14.21. A. (2) Based on resident record review, the assisted living program failed to collect written information	E2800		

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E2800	Continued From page 7 about the resident ' s physical condition and medical status on the Resident Assessment Tool within 30 days of admission. Findings include: Resident #2 was admitted to the facility on 12/18/13. Documentation was unable to be found that the ALM or designee completed a functional assessment of Resident #2 within 30 days before admission.	E2800		
E2830	.21 B4 .21 Preadmission Requirements (4) Information on the assessment shall include at a minimum: (a) Recent medical history, including any acute medical conditions or hospitalizations; (b) Significant medical conditions affecting functioning, including the individual's ability for self-care, cognition, physical condition, and behavioral and psychosocial status; (c) Other active and significant chronic or acute medical diagnoses; (d) Known allergies to foods and medications; (e) Medical confirmation that the individual is free from communicable tuberculosis, and other active reportable airborne communicable diseases; (f) Current and other needed medications; (g) Current and other needed treatments and services for medical conditions and related problems; (h) Current nutritional status, including height, weight, risk factors, and deficits; (i) Diets ordered by a physician; (j) Medically necessary limitations or precautions; and (k) Monitoring or tests that need to be performed or followed up after admission.	E2830		

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E2830	Continued From page 8 This REQUIREMENT is not met as evidenced by: 10.07.14.21. B. 4 (e) Based on resident record review, pertinent resident information failed to be included on the Resident Assessment Tool. Findings include: Review of Resident #5 ' s record failed to provide documentation of medical confirmation that Resident #5 was free from communicable tuberculosis and any other active reportable communicable diseases.	E2830		
E3370	.26 C2 .26 Service Plan (2) The service plan is developed within 30 days of admission to the assisted living program; and This REQUIREMENT is not met as evidenced by: 10.07.14.26 C (2) Based on resident record review, the facility failed to ensure that service plans are developed within 30 days of admission for all residents. Findings include: Resident #2 was admitted to the facility on 12/18/13. Review of Resident #2 ' s record failed to provide documentation of a completed service plan. Interview with the ALM revealed that the service plan for Resident #2 has not been developed yet. Resident #3 was admitted to the facility on 10/23/13. Review of Resident #3 ' s record failed to provide documentation of a completed service plan. Interview with the ALM revealed that the	E3370		

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E3370	Continued From page 9 service plan for Resident #3 has not been developed. Resident #4 was admitted to the facility on 12/4/13. Review of Resident #4 ' s record provided no documentation of a completed service plan. Interview with the ALM revealed that the service plan for Resident #4 has not been developed. Resident #5 was admitted to the facility on 12/27/13. Review of Resident #5 ' s record provided no documentation of a completed service plan. Interview with the ALM revealed that the service plan for Resident #5 has not been developed.	E3370		
E3380	.26 C3 .26 Service Plan (3) The service plan is reviewed by staff at least every 6 months, and updated, if needed, unless a resident's condition or preferences significantly change, in which case the assisted living manager or designee shall review and update the service plan sooner to respond to these changes. This REQUIREMENT is not met as evidenced by: 10.07.14.26 C (3) Based on resident record review, the ALM or designee, failed to review and update service plans at least every 6 months, or sooner, if a resident ' s conditions or preferences significantly change. Findings include: Review of Residents # 1 ' s record revealed that the service plan for Resident # 1 has not been updated since 3/21/13.	E3380		

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E3380	Continued From page 10 Review of Resident # 6 ' s service plan revealed that the last review by staff was completed on 2/20/13, more than 6 months ago. Review of the service plan in the record dated 2/20/13 revealed the following services were not addressed; Resident #6 is lactose intolerant and has a diet order for mechanical soft, thin regular liquids. Staff is to monitor the food intake of Resident #6 and monitor for any difficulties when swallowing. Resident #6 is prescribed Coumadin a high risk blood thinner. The service plan failed to address the need to monitor the resident for bleeding precautions and monitoring of the resident ' s PT/INR (determines blood clotting time). The service plan for this resident failed to address the diagnosis of edema of the lower extremities is being treated by wound care for weeping to the lower left leg and is to receive the medication Lasix (a diuretic) daily.	E3380		
E3420	.27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility; (d) On return from medical appointments and when seen in home by any health care provider; (e) On return from nonroutine leaves of absence; and (f) When the resident is discharged permanently from the facility, including the location and manner of discharge.	E3420		

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E3420	Continued From page 11 (2) Staff shall write care notes that are individualized, legible, chronological, and signed by the writer. This REQUIREMENT is not met as evidenced by: 10.07.14.27. D (1) Based on resident record review, the staff failed to write care notes on admission, at least weekly and with any significant changes in the resident ' s condition, including when incidents occur and any follow-up action is taken. Findings include: Review of Resident # 1 ' s record revealed the last care note written by staff was on 1/4/14. Resident #2 was admitted to the facility on 12/18/14. Documentation review of Resident #2 ' s record failed to reveal any care notes. Interview with the ALM failed to reveal any further documentation. Review of Resident # 4 ' s record revealed that the last care note written by staff was on 12/26/13. Interview with the ALM provided no further documentation. Resident #5 was admitted to the facility on 12/27/14. Review of Resident #5 ' s record provided no documentation of care notes written by staff. Interview with the ALM revealed that care notes have not been written for Resident #5. Review of Resident # 6 ' s record revealed that the last care note written by staff was on 12/10/13. Interview with the ALM provided no further documentation.	E3420		

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E3710	Continued From page 12	E3710		
E3710	.29 O .29 Medication Management and Administration O. Accounting for Narcotic and Controlled Drugs. (1) Staff shall count and record controlled drugs, such as narcotics, before the close of every shift. (2) The daily record shall account for all controlled drugs documented as administered on the medication administration record. (3) All Schedule II and III narcotics shall be maintained under a double lock system. This REQUIREMENT is not met as evidenced by: 10.07.14.29.0 (1) (2) Based on review of resident records, medical orders, the residents medications and the controlled drug book, staff failed to count and record the controlled drugs before the close of every shift and the narcotic count sheet failed to reconcile with the physical count. Findings include: Review of the narcotic count sheets revealed the staff is not counting narcotics at the end of each shift. Resident #5 has a medical order for Alprazolam 0.25 mg. - take 1/2 tablet by mouth three times a day for anxiety. The controlled drug sheet for this medication for Resident #5 listed 29 tablets. The physical count was 28 tablets. Resident #7 has a medical order for Morphine Sulfate (for moderate to severe pain) - 20 mg. mg/ml- as needed for pain. The facility narcotic count indicated there were 10 syringes remaining. The physical count revealed there were 8 syringes remaining. Interview with the ALM revealed that the Hospice nurse used two of the	E3710		

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E3710	Continued From page 13 syringes for another resident.	E3710		
E3770	.31 A .31 Incident Reports .31 Incident Reports. A. Staff of the assisted living program shall complete an incident report within 24 hours of having knowledge that an incident, as defined in Regulation .02B(35) of this chapter, occurred. This REQUIREMENT is not met as evidenced by: 10.07.14.31. A Based on record review, the assisted living program failed to complete an incident report within 24 hours of having knowledge that an incident occurred. Findings include: Review of Resident #6 ' s record reveals that on 6/27/13, Resident #6 was sent to the hospital on 6/27/13 due to a fall and was diagnosed with a left shoulder fracture. Review of Resident #6 ' s record failed to provide documentation of a completed incident report. Interview with the ALM revealed no further documentation.	E3770		
E4800	.46 C3 .46 Emergency Preparedness (3) When the assisted living program relocates residents, the program shall send a brief medical fact sheet with each resident that includes at a minimum the resident's: (a) Name; (b) Medical condition or diagnosis; (c) Medications; (d) Allergies; (e) Special diets or dietary restrictions; and (f) Family or legal representative contact	E4800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E4800	Continued From page 14 information. This REQUIREMENT is not met as evidenced by: 10.07.14.46 C. (3) Based on review of the facility emergency disaster plan, the facility failed to ensure that all information documented on the plan is current. Findings include: Review of the facility emergency plan revealed that the staff information, the client roster and the family or legal representative contact information is not current.	E4800		
E4810	.46 C4 .46 Emergency Preparedness (4) The brief medical fact sheet for each resident described in §C(3) of this regulation shall be: (a) Updated upon the occurrence of change in any of the required information; (b) Reviewed at least monthly; and (c) Maintained in a central location readily accessible and available to accompany residents in case of an emergency evacuation. This REQUIREMENT is not met as evidenced by: 10.07.14.46. C (4) Based on administrative record review, the assisted living program failed to update the medical fact sheets for each resident monthly. Findings include: Review of the assisted living program ' s emergency disaster plan revealed that medical fact sheets were last reviewed on 4/27/12.	E4810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02AL0241	A. BUILDING: _____ B. WING _____	R 01/30/2014

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E4900	Continued From page 15	E4900		
E4900	.46 E2 .46 Emergency Preparedness (2) Fire Drills. (a) The assisted living program shall conduct fire drills at least quarterly on all shifts. (b) Documentation. The assisted living program shall: (i) Document completion of each drill; (ii) Have all staff who participated in the drill sign the document; and (iii) Maintain the documentation on file for a minimum of 2 years. This REQUIREMENT is not met as evidenced by: 10.07.14.46. E (2) Based on administrative record review, the assisted living program failed to conduct fire drills at least quarterly on all shifts. Findings include: Review of the administrative records revealed that the assisted living program last fire drill was conducted on 7/12/13.	E4900		
E4910	.46 E3 .46 Emergency Preparedness (3) Semiannual Disaster Drill. (a) The assisted living program shall conduct a semiannual emergency and disaster drill on all shifts during which it practices evacuating residents or sheltering in-place so that each is practiced at least one time a year. (b) The drills may be conducted via a table-top exercise if the program can demonstrate that moving residents will be harmful to the residents.	E4910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E4910	Continued From page 16 (c) Documentation. The assisted living program shall: (i) Document completion of each disaster drill or training session; (ii) Have all staff who participated in the drill or training sign the document; (iii) Document any opportunities for improvement as identified as a result of the drill; and (iv) Keep the documentation on file for a minimum of 2 years. This REQUIREMENT is not met as evidenced by: 10.07.14.46. E.3 (a-c) Based on administrative record review, the assisted living program failed to conduct a semiannual emergency disaster drills on all shifts during which it practices evacuating residents or sheltering-in-place so that each is practiced at least one time a year. Findings include: Review of the emergency disaster drills conducted by the assisted living program failed to provide documentation that a semiannual evacuation drills and a sheltering in- place drill had not been conducted for 2013.	E4910		